Réseau de cancérologie Rossy | Rossy Cancer Network

Improving turnaround time for pathology results and evaluating the effectiveness of a joint tumour board between the JGH and MUHC

RCN Gynecology Disease Site Group

GYN-ONC DS CO-LEADS

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Co-lead objectives

- Identify indicators together
- Improve/standardize care based on identified indicators
- Improve and standardize treatment through joint multidisciplinary tumour boards
- Organize workshops to improve collaboration

The group is supported by Jida El Hajjar, RCN project manager and Sarita Benchimol, RCN site facilitator.

2017/2018 PRIORITIES

GY2 Indicator: Postoperative length of stay (POLOS) for patients with gynecological cancer at RCN hospitals.

• Outcomes measurement such as POLOS is a standard approach to quality improvement in the field of surgery.

• Variables that extend post-op hospital stay:

- o postoperative complications
- o differences in practice among hospitals and physicians.
  - o variable adoption of new surgical technologies, such as minimally invasive or robotic approaches, as well as difference in implementation of enhanced recovery pathways[1,2]
- o stage, co-morbidity, surgeon expertise and volume.

HOW COULD THIS INDICATOR LEAD TO IMPROVED CARE?

• A better understanding of the POLOS and associated rate of readmission and ED visits for patients undergoing gynecology surgeries can lead to policy implications and targeted interventions. Such interventions could include increased access to outpatient nursing care or follow-up visits, the creation of functional templates to assess patients at risk and capture complications of treatment, or other quality initiatives (such as ERAS protocols) aimed at reducing the risk of unplanned hospital visits

Improve patient accrual into clinical trials

• Ensure listing of clinical trials on RCN website is current
• Encourage each other in clinical trial recruitment, transferring patients between sites as necessary

Support each other's efforts in improving cancer care quality and innovation:

2014 CQI Research recipient
Shirin Shallwani
Improving our understanding of the value of early compression therapy on the incidence of lymphedema in patients treated for gynecological cancer.

2017 CQI Research recipient
Lucie Gilbert
Finding effective discriminators to triage type of endometrial cancer surgery.

INDICATOR GY1: Pathology turnaround time (TATs) for biopsies and surgical specimens

- TATs have been identified by patients, clinicians and pathologists as essential in determining pathology care quality.
- The MSSS target turnaround time for biopsies is 5 working days and 10 working days for surgeries (from time received in pathology department to final pathology report). Some samples requiring additional immunohistochemistry testing may require up to an additional 2 working days. The MSSS aims that 80% of reports be completed within those specified turnaround times.
- Cancer Care Ontario reports that ~75% of surgical pathology reports are completed within 14 days (2014 data) and their target is that >85% of path reports be completed within 14 days.
- We analyzed N=2329 records of patients diagnosed from FY 2013 Oct2017.

***Table 1**: Average time (working days) from procedure to final report for gynecologic cancers. Data reported from date of procedure (not laboratory receipt date) to date of final pathology report, as this was found to be more pertinent. However, in >75% of cases, the date of laboratory receipt is between 0-1 day after the date of procedure, so the data should meet the MSSS targets.*

	2013-14	2014-15	2015-16	2016-Oct2017
Major surgery (target: 10 working days)				
JGH	13	16.9	11.7	10.8
MUHC	11.8	13.0	11.1	11.3
SMHC	27.2	17.3	10.9	14.8
Minor surgery (target: 10 working days)				
JGH	12.1	18.5	10.5	10.0
MUHC	11.0	13.3	11.1	11.8
SMHC	14.2	10.0	14.0	14.0
Biopsy & curettage (target: 5 working days)				
JGH	8.7	9.5	8.6	6.0
MUHC	7.0	5.7	6.4	6.4
SMHC	15.1	7.6	5.4	5.0

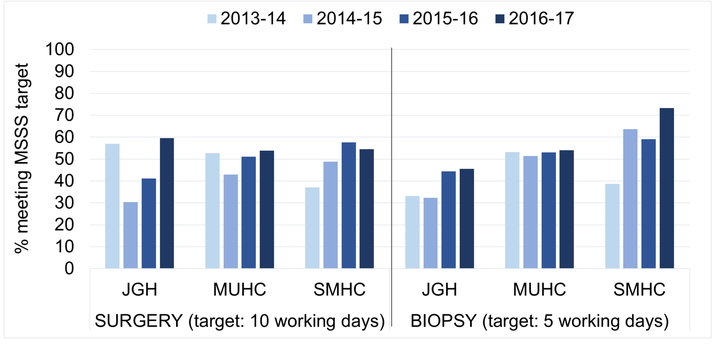


***Fig 2**: Percent of gynecology surgical or biopsy specimens meeting Ministry targets*

What do the results mean?

➢This indicator was selected by the gynecology DS group in Jan 2015 as they felt that there were delay issues that needed to be addressed.

➢While none of the hospitals are reaching the target of >80% reports completed within 10 working days for surgeries and 5 working days for biopsies, improvements have been made in the most recent year of analysis.

Efforts in this area

➢In June 2015, the JGH implemented pathology synoptic reporting for gynecology. This was the last tumour type to adopt synoptic reporting at the JGH. Additionally, they optimized workflow processes. This has resulted in significant improvement in subsequent years.

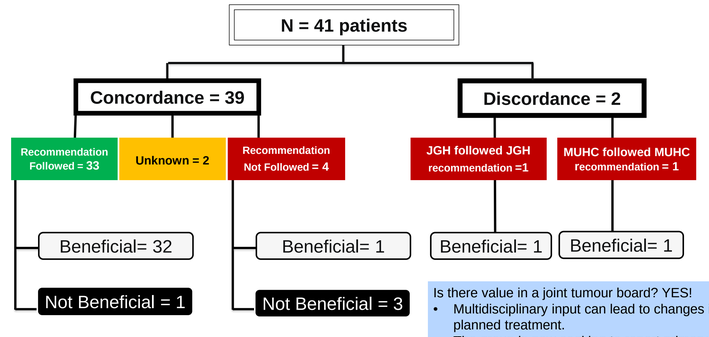
QI initiative: Effectiveness of a joint gyne-onc tumour board between MUHC and JGH

• Tumour boards are the cornerstone of multidisciplinary cancer care.
• A joint tumor board between JGH and MUHC was established to discuss complex cases (weekly, Friday at 8:30am)
• We conducted an audit of the joint tumour board from Dec 2015 to Dec 2016 to assess:

- participation — 50% of joint TB were cancelled, due primarily to scheduling conflicts by both sites (ex. Stat holidays, conferences, etc.)
- data reporting and completion — 60% of CDTC notes at JGH were present in pt chart. 50% at MUHC. This will improve in 2017 due to the implementation of electronic TB forms by the DS group.
- adherence to recommendations and outcome — Resident Dr. Kyrie Wang reviewed the clinical chart of patients to assess adherence to joint TB recommendations and pt clinical outcome (ECOG, disease response, symptom worsening, and hospitalization rate)

Results

• 83% of joint tumour board recommendations were adhered to and were beneficial for the patients. **What is an appropriate target here?**
• The group is planning a second audit to continue the evaluation of these meetings and learn from cases were recommendations were not beneficial.



Is there value in a joint tumour board? YES!
- Multidisciplinary input can lead to changes in planned treatment.
- The group is now seeking to report primary opinion first and see if discussions alter the primary plan and if recommendations were followed.

***Fig 3**: Effectiveness of the joint tumour board. Concordance was defined as both sites (JGH and MUHC) agreeing on the same recommendations. Discordance was defined as both site recommending different treatment plans.*

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